AHCCCS

Our first care is your health care
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

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Provider Address Update Form Instructions

Name Box: The provider's *last name*, *first name* and *middle initial* are required in this section. Note:* The AHCCCS P*rovider ID#* is the identification number assigned by AHCCCS.
(AHCCCS Provider identification number is mandatory in this field).

Check One Area: *Add* or *replace* must be indicated. If the provider has not made a choice in either box, *add* or *replace*, the information provided on the form will be added to information already in the AHCCCS system with one exception – *Correspondence* address will not be changed.

Addresses: *Correspondence* and the *Pay-To addresses* may be a Post Office Box or a street address. The *Service address* must be a street address.

Signature Box: Please note that this area can be signed and dated only by the provider or authorized signor that is on file with AHCCCS. If this area is not completed the form will be returned to the provider. (Also, you can refer to your copy of the registration packet – Section IV – for the authorized signor information). Stamped signatures are not acceptable.

Please Note: A W-9 (**Request for taxpayer identification number and certification**) form is required with each update submission.